Atlas Therapy, Specialized Physical Therapy

ACKNOWLEDGEMENT OF RECEIPT OF THE FINANCIAL POLICY

I acknowledge that I have received, reviewed, and understand Atlas Therapy's Financial Policy.

Date: _____

Name of Patient: _____ DOB: _____
Print Name

1) PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS
2) COLLECTION OF PAYMENT
3) MISSED APPOINTMENTS/ NO SHOWS/ LATE FOR APPOINTMENTS
4) MEDICARE PAYMENT
5) NON-CONTRACTED INSURANCE (Out of Network)
6) SELF-PAY
7) REFERRALS
8) ASSIGNMENT OF BENEFITS

_____

Signature of Patient/Personal Representative